



IN - HOSPITAL - DBL

In - Hospital Statement of Claim

COMPLETE THIS FORM AND RETURN TO:

**First Rehabilitation Life
600 Northern Boulevard
Great Neck, New York 11021-5202
ATE: DISABILITY CLAIMS DEPT.**

Claimant: _____
Claim No: _____
Date: _____

PART 1 TO BE COMPLETED BY INSURED

Name _____ Employed By _____
Address: _____ Town, State: _____
Birth Date _____ Sex _____ SS# _____
Admission Date _____ Discharge Date: _____

REQUIRED STATEMENT: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."

I authorize any individual of organization to release any information to First Rehabilitation Life Insurance Company of America for any services or benefits received or payable to me or on my behalf.

Signature of Eligible Insured _____ Date _____

PART 2 TO BE COMPLETED BY HOSPITAL IN LIEU OF BC/RS VOUCHER

Please Note: This section is not to be completed if the BC/RS voucher showing hospitalization date(s) is returned with this form.

- Name of Hospital _____
Location _____
- Patient _____ Last Name _____ First Name _____ Middle Name _____ Hospital No. _____
Age _____ Sex _____ If Minor, Name of Guardian _____
- Admitted (Date) _____ Discharged (Date) _____
Total Days Hospitalized _____
- Was patient in Intensive Care Unit during hospitalization? _____ Yes _____ No
If yes, furnish dates of such I.C.U. confinement
From _____ To _____
- If patient is still hospitalized, please indicate expected duration of current hospitalization. _____
- Diagnosis: _____

Date: _____ Medical Records Librarian or Authorized Designee _____